TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MedAlert Occupational Management

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-1123-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requestor maintains that all information required by the Texas Administrative Code has been submitted to the Carrier and services provided by our office on behalf of the insured are due proper reimbursement."

Amount in Dispute: $221.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2016	99080, L4360, A9273, E0114	$221.00	$216.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. 28 Texas Administrative Code §134.1 sets out medical reimbursement guidelines.
4. 28 Texas Administrative Code §133.210 sets out the requirements for medical documentation.
5. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are carrier's denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Was support of fair and reasonable amount submitted?
4. Is payment due for work status report?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for a work status reports and durable medical equipment provided in an office setting on July 21, 2016.

   The insurance carrier denied disputed services with denial code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

   28 Texas Administrative Code §133.210 (a) and (b) states

   > (a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.
   >
   > (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

   Review of the submitted information finds the office exam note dated July 21, 2016 includes the following; "Recommended work status (claimant's) recommended work status is Regular Duty" and "Durable medical equipment he was given an applied a gel pack, 3D walking boot, a pair of crutch for protections, to limit his weight bearing and decrease swelling, pain, facilitate recovery."

   Therefore, the carrier's denial for lack of information not upheld. The services in dispute will be reviewed per applicable fee guidelines.

2. The reimbursement guidelines pertaining the Durable Medical Equipment is found at 28 Texas Administrative Code §134.203 (d) which states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
   > >
   > > (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
   > >
   > > (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   Review of the applicable DMEPOS fee schedule found at www.cgsmedicare.com, finds the following:

- Code L4360 – "Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise."

  The allowable shown is $246.82. The maximum allowable reimbursement calculation is $246.82 x 125 % or $308.53. However the submitted charge or usual and customary charge found on the claim line $145.00. Therefore the provisions of 28 Texas Administrative Code 134.203(h) applies which states,

  > When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
  >
  > (1) MAR amount;
  >
  > (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

  Based on the above the amount payable is $145.00

- Code E0114 – "Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips."

  The allowable shown for the "NU" modifier is $45.52. The maximum allowable reimbursement calculation is $45.52 x 125% = $56.90. However, as stated above as the provider's usual and customary charge is less than MAR, the lesser charge of $56.00 is the payable amount.

3. For submitted code A9273, review of the 2016 Medicare DMEPOS and Medicaid fee schedule finds no allowable amount for this code in dispute, therefore 28 Texas Administrative Code 134.203(d)(3)which states,

   > if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   28 Texas Administrative Code §134.203(f) states,

   > For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

   28 Texas Administrative Code §134.1(e) states,

   > Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
   >
   > (1) the Division's fee guidelines;
   > (2) a negotiated contract; or
   > (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section

   28 Texas Administrative Code §134.1 (f) states,

   > Fair and reasonable reimbursement shall:
   >
   > (1) be consistent with the criteria of Labor Code §413.011;
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §133.307(c)(2)(O), requires,

> documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how reimbursement of $5.00 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. No additional payment is recommended

4. 28 Texas Administrative Code §129.5 (i) states in pertinent part,

> Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows:
>
> (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;

Review of the submitted medical claim finds the provider submitted code 99080 with the “73” modifier. Within the submitted documentation, a copy of “Work status report” dated July 21, 2016 was found. Therefore, based on the above the provider has met the Division guidelines and $15.00 allowed.

5. The total allowed amount is ($145.00 + $56.00 + $15.00) = $216.00. The carrier previously paid $0.00. Therefore, the remaining balance of $216.00 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $216.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $216.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.